



Name: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SVS #: \_\_\_\_\_  

Last
First
M D Y

### TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

**Student, Please answer the following questions:**

**Circle One**

1) Have you ever had a <b>positive</b> TB test?	Yes    No
2) Have you ever had <b>close contact</b> with persons known or suspected to have active TB disease?	Yes    No
3) Were you <b>born</b> in one of the countries listed below? If yes, please CIRCLE the country.	Yes    No
4) Have you had any <b>frequent or prolonged stays (30 days or more)</b> to one or more of the countries listed below? If yes, please CHECK ✓ the country/ies below.	Yes    No
5) Have you been a resident or employee of high-risk congregate settings (e.g., correctional facility, long-term care facility, homeless shelter)?	Yes    No
6) Have you ever been a volunteer or health-care worker who served clients who are at risk for active TB disease?	Yes    No
7) Have you ever been a member of any of the following groups that may have an increased incidence of latent TB infection or active TB disease: medically underserved, low-income, or abusing drugs and/or alcohol?	Yes    No

- |   |   |   |   |  |
|---|---|---|---|--|
| Afghanistan<br>Algeria<br>Angola<br>Argentina<br>Armenia<br>Azerbaijan<br>Bahrain<br>Bangladesh<br>Belarus<br>Belize<br>Benin<br>Bhutan<br>Bolivia (Plurinational State of)<br>Bosnia & Herzegovina<br>Botswana<br>Brazil<br>Brunei Darussalam<br>Bulgaria<br>Burkina Faso<br>Burundi<br>Cabo Verde<br>Cambodia<br>Cameroon<br>Cape Verde<br>Central African Republic<br>Chad<br>China (including Taiwan)<br>Colombia<br>Comoros<br>Congo | Côte d'Ivoire<br>Congo (Democratic Republic of the)<br>Democratic People's Republic of Korea<br>Democratic Republic of the Congo<br>Djibouti<br>Dominican Republic<br>Ecuador<br>El Salvador<br>Equatorial Guinea<br>Eritrea<br>Estonia<br>Ethiopia<br>Fiji<br>Gabon<br>Gambia<br>Georgia<br>Ghana<br>Guam<br>Guatemala<br>Guinea<br>Guinea-Bissau<br>Guyana<br>Haiti<br>Honduras<br>India<br>Indonesia<br>Iran (Islamic Republic of) | Iraq<br>Kazakhstan<br>Kenya<br>Kiribati<br>Korea (Democratic People's Republic of)<br>Kuwait<br>Kyrgyzstan<br>Lao People's Democratic Republic<br>Latvia<br>Lesotho<br>Liberia<br>Libya<br>Lithuania<br>Madagascar<br>Malawi<br>Malaysia<br>Maldives<br>Mali<br>Marshall Islands<br>Mauritania<br>Mauritius<br>Mexico<br>Micronesia (Federated States of)<br>Mongolia<br>Morocco<br>Mozambique<br>Myanmar | Namibia<br>Nauru<br>Nepal<br>Nicaragua<br>Niger<br>Nigeria<br>Niue<br>Pakistan<br>Palau<br>Panama<br>Papua New Guinea<br>Paraguay<br>Peru<br>Philippines<br>Poland<br>Portugal<br>Qatar<br>Republic of Korea<br>Republic of Moldova<br>Romania<br>Russian Federation<br>Rwanda<br>St. Vincent & The Grenadines<br>Sao Tome & Principe<br>Senegal<br>Serbia<br>Seychelles<br>Sierra Leone<br>Singapore | Solomon Islands<br>Somalia<br>South Africa<br>South Sudan<br>Sri Lanka<br>Sudan<br>Suriname<br>Swaziland<br>Tajikistan<br>Tanzania (United Republic of)<br>Thailand<br>Timor-Leste<br>Togo<br>Trinidad & Tobago<br>Tunisia<br>Turkey<br>Turkmenistan<br>Tuvalu<br>Uganda<br>Ukraine<br>Uruguay<br>Uzbekistan<br>Vanuatu<br>Venezuela (Bolivarian Republic of)<br>Viet Nam<br>Yemen<br>Zambia<br>Zimbabwe |
|---|---|---|---|--|

*Moderate to High Incidence Countries with TB incidence rates of ≥ 20 cases per 100,000 population in 2012. Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012*

**If you answered YES to one or more of the above questions, Saint Vincent Seminary requires that a physician, nurse practitioner, or physician assistant complete the Physician's Evaluation for Tuberculosis (page 3). If you answered NO to all the above questions, SKIP PAGE 3 and PROCEED TO PAGE 4.**

**TO BE COMPLETED AND SIGNED BY A PHYSICIAN, PA OR NP IF PAGE 2 HAS ONE OR MORE "YES" ANSWERS.**

PHYSICIAN'S EVALUATION FOR TUBERCULOSIS

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last First M D Y

1. Has the student had a TB TEST in the past?  Yes  No  Unknown
2. Has the student had a POSITIVE TB test in the past?  Yes  No

If YES, what test was positive:  Interferon-Gamma Release Assay (IGRA)  TB skin test – Result in mm: \_\_\_\_\_

Date of Positive Test: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
M D Y

Chest X-Ray Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. (Copy of Radiologist's report in ENGLISH must be attached.) Result: Normal  Abnormal

Diagnosis: ACTIVE Tuberculosis  Yes  No LATENT Tuberculosis  Yes  No

Treatment: \_\_\_\_\_ Completed successfully on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
M D Y

**3. TB SYMPTOM CHECK**

Does the student have signs or symptoms of active pulmonary tuberculosis disease?

No  Proceed to #4

Yes  Check symptoms present & proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest x-ray, and sputum evaluation as indicated.

- Cough (especially if lasting 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

**4. TB TEST -** If no history of a Positive TB test, perform one of the following tests within 6 months before start of classes:

• TB Skin Test: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ TB Skin Test read: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result in mm: \_\_\_\_\_ Neg  Pos   
M D Y M D Y

• Interferon Gamma Release Assay (IGRA): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Neg  Pos  Copy of laboratory report must be attached.  
M D Y

**5. CHEST X-RAY** if TB test noted above is POSITIVE. **Copy of Radiologist's report in ENGLISH must be attached.**

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Interpretation: Normal  Abnormal   
M D Y

Diagnosis: ACTIVE Tuberculosis  Yes  No LATENT Tuberculosis  Yes  No Other: \_\_\_\_\_

**Not Valid unless signed and sealed:**

**Office Seal (required)**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Office Telephone: \_\_\_\_\_

TO BE COMPLETED BY A PHYSICIAN, PA, NP, OR RN

## RECORD OF IMMUNIZATION

Student's Name: \_\_\_\_\_  
Last First

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

### REQUIRED FOR ALL STUDENTS

**MEASLES, MUMPS, RUBELLA (MMR)** (students born BEFORE 1957 are exempt from the MMR requirement)

OR → ↓	<p><b>2 doses of MMR VACCINE</b></p> <p>Dose 1 RECEIVED AFTER 1968 &amp; ≥ 12 MONTHS OF AGE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1<sup>ST</sup> DOSE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>	OR	<p><b>LABORATORY PROOF OF IMMUNITY</b> (see below) ↓</p>
<p><b>2 doses of MEASLES VACCINE</b></p> <p>Dose 1 RECEIVED AFTER 1968 &amp; ≥ 12 MONTHS OF AGE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1<sup>ST</sup> DOSE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>		OR	<p>MEASLES Virus IgG Antibody test demonstrating immunity.</p> <p>Copy of laboratory report must be attached.</p>
<p><b>2 doses of MUMPS VACCINE</b></p> <p>Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1<sup>ST</sup> DOSE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>		OR	<p>MUMPS Virus IgG Antibody test demonstrating immunity.</p> <p>Copy of laboratory report must be attached.</p>
<p><b>1 dose of RUBELLA VACCINE</b></p> <p>Dose 1 RECEIVED ≥ 12 MONTHS OF AGE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>		OR	<p>RUBELLA Virus IgG Antibody test demonstrating immunity.</p> <p>Copy of laboratory report must be attached.</p>

**VARICELLA (Chickenpox)**

<p><b>2 doses of VARICELLA VACCINE</b></p> <p>Dose 1 RECEIVED ≥ 12 MO OF AGE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>Dose 2 RECEIVED ≥ 28 DAYS FROM 1<sup>ST</sup> DOSE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p>	OR	<p><b>LABORATORY PROOF OF IMMUNITY</b>                  Varicella Zoster Virus (VZV)                  IgG Antibody test.</p> <p>Copy of laboratory report must be attached.</p>	<p><b>History of Chickenpox Infection</b></p> <p>Date: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p><i>History of injection alone is not acceptable for students entering the health care field. Must receive 2 doses of Varicella vaccine or provide proof of immunity to Varicella.</i></p>
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**TETANUS, DIPHTHERIA, PERTUSSIS**

<p><b>1 dose of TETANUS, DIPHTHERIA, PERTUSSIS VACCINE</b> RECEIVED ≥ 11 YEARS OF AGE: ____/____/____  <small style="margin-left: 100px;">M</small> <small style="margin-left: 20px;">D</small> <small style="margin-left: 20px;">Y</small></p> <p>NOTE: Vaccination MUST include Pertussis to be acceptable. If not, revaccinate with Tdap.</p>
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*Continued on next page*

Student's Name: \_\_\_\_\_  
Last First

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Continued - REQUIRED FOR ALL STUDENTS

<b>HEPATITIS B (NOTE: If beginning vaccination series, no need to accelerate dosing. Series can be completed at SVS)</b>				
<b>3 doses of HEPATITIS B VACCINE</b>	<b>OR</b>	<b>3 doses of Combined HEPATITIS A &amp; HEPATITIS B VACCINE</b>	<b>OR</b>	<b>LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B</b>  Copy of laboratory report must be attached.
Dose 1: ____/____/____ M D Y		Dose 1: ____/____/____ M D Y		
Dose 2: ____/____/____ M D Y		Dose 2: ____/____/____ M D Y		
Dose 3: ____/____/____ M D Y		Dose 3: ____/____/____ M D Y		

REQUIRED FOR ALL STUDENTS

**MENINGOCOCCAL MENINGITIS A, C, Y, W-135**

1 dose of Meningococcal Meningitis A, C, Y, W-135 Vaccine RECEIVED  $\geq$  16 YEARS OF AGE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

NOTE: Give Booster dose if received before age 16

BRAND NAME of VACCINE: \_\_\_\_\_

OTHER VACCINATIONS (**NOT REQUIRED**):

**MENINGOCOCCAL B (MenB) (for ages 16-23)**

Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

**HEPATITIS A**

Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

**OR**

**Combined Hepatitis A & Hepatitis B Vaccine**

(Document dates of doses on page in box above)

**HUMAN PAPILLOMAVIRUS (HPV)**

Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Dose 3: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

**PNEUMOCOCCAL**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Type Received: \_\_\_\_\_

**SHINGLES VACCINE:**

Date: \_\_\_\_\_

	YES	NO	WHEN	
Scarlet Fever				
Measles				
German measles				
Mumps				
Chicken Pox				
Malaria				
Rheumatic Fever, Heart				
Blood Transfusion				
<i>Surgery(ies)</i>				<i>Type of:</i>
<i>Frequent Depression</i>				<i>Medication:</i>
<i>Frequent Anxiety</i>				<i>Medication:</i>
<i>Other Medical Conditions?</i>				

Are there any irregularities of the following systems? If yes please describe.

	Normal	Abnormal
Head, ears, nose or throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Endocrine		
Neuropsychiatric		
Skin		
Teeth		
<b>Allergies to Medication, Food, Other:</b>		

Recommendations for physical activity: Unlimited or Limited: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Is the patient now under treatment for any medical or emotional condition? Yes No

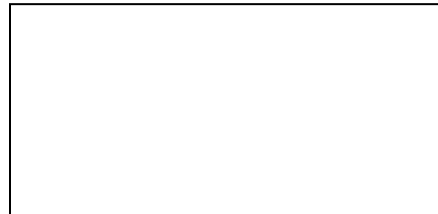
Do you have any recommendations regarding the care of this student? Yes No. If "yes," what are they?

Office Stamp (Required)

Physician's Name & Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Office Telephone: ( ) \_\_\_\_\_



**STUDENT'S or APPLICANT'S PERMISSION FOR USE:**

*I, the undersigned, have freely and knowingly supplied all information contained in this document to Saint Vincent Seminary and/or Archabbey as part of my admissions procedure to either the seminary or the monastery. I grant full permission and access to the information contained in these documents to the administration, admissions staff, infirmary, College Health Center, medical staff, and to the Health Care administrator of both the Seminary and the Monastery for the purposes of my admissions procedures and for my personal healthcare, insurance, and medical needs. This permission remains in effect until such time that I revoke this authorization in writing to the above named recipients, except for that information which has already been released in accordance with the authorization prior to my revocation.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**Pennsylvania State Law and Meningitis and Meningococcal Disease**

*The Pennsylvania College and University Student Vaccination Act*, signed into law in June 2002, requires students living in campus housing in the state of Pennsylvania to be immunized against meningococcal disease or to sign a waiver that they have received detailed information on the risks associated with meningococcal disease and the availability and the effectiveness of vaccine and that they choose not to be vaccinated.

In accordance with this act Saint Vincent College and Seminary have implemented the following requirements. These requirements apply to all students living on campus, including students enrolled in campus-based residential summer programs. All students who will be living in campus housing and who are age 21 or younger **must submit proof of 1 dose of meningococcal conjugate vaccine (MCV4) that covers serogroups A, C, Y, and W-135 since age 16.** Students are exempt from this requirement only if there is a medical contraindication to vaccination or if religious beliefs prohibit immunization. Requests for exemption must be accompanied by a signed waiver.

Students living on campus who are over age 21 may either submit proof of vaccination since age 16 or submit the Meningococcal Immunization Waiver in accordance with the College and University Student Vaccination Act. Due to the short time frame of summer-only residential programs, students enrolled in these programs must be in compliance prior to arrival on campus.

Those students who are not in compliance after arrival may obtain this immunization through the College Health Center or the Monastery Infirmary (for Monastery residents) at the student's expense.

Incoming students may request a medical or religious exemption. Requests must include a signed statement from an allopathic or osteopathic physician indicating why this vaccine is medically contraindicated. Requests for religious exemption must include a detailed written statement of personal religious beliefs or a letter from clergy. All requests must include a signed Meningococcal Immunization Waiver (see below).

***Additional information about meningococcal disease and vaccine is available at:***

- the American College Health Association ([www.acha.org](http://www.acha.org)),
- Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/meningococcal/index.html>
- Vaccine Information Statement at <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html>



## SAINT VINCENT SEMINARY AND ARCHABBEY

### INFORMATION ABOUT MENINGOCOCCAL DISEASE AND WAIVER FORM

Meningococcal disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually.

Approximately 100 to 125 cases of meningococcal disease occur annually on college campuses and five to 15 students die as a result. Serotypes C, Y and W-125 cause a majority of cases in college students (65 percent). Research has shown that students residing in dormitories appear to be at higher risk for meningococcal disease than college students overall. Further research shows freshmen living in dormitories have a six times higher risk of meningococcal disease than college students overall.

Meningococcal vaccine provides protection against the most common strains of the disease, including serogroups A, C, Y and W-135. ***The duration of protection is approximately three to five years.*** The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days.

The Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that college freshmen (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination, and that students who wish to reduce their risk for meningococcal disease be immunized. Other undergraduate students who wish to reduce their risk for meningococcal disease may also choose to be vaccinated.

Under the terms of the College and University Student Vaccination Act of the state of Pennsylvania, students living in campus housing must be immunized against meningococcal disease or sign a waiver that they have received detailed information on the risks associated with meningococcal disease and the availability and the effectiveness of vaccine and that they choose not to be vaccinated.

***All students who will be living in campus housing or the monastery and who are age 21 or younger must submit proof of 1 dose of meningococcal conjugate vaccine that covers serogroups A, C, Y, and W-135 since age 16. Incoming students living on campus who are over age 21 may either submit proof of vaccination since age 16 or submit the Meningococcal Immunization Waiver in accordance with the College and University Student Vaccination Act.***

### WAIVER

*I have read the above information about the risks of meningococcal disease and the benefits of immunization. I hereby attest that I am declining immunization at this time. ***Incoming students may waive this requirement only if there is a medical contraindication to vaccination or if religious beliefs prohibit immunization.****

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Student name (printed)

\_\_\_\_\_  
Signature of parent (if under 18)

\_\_\_\_\_  
Parents name (if under 18) (printed)

\_\_\_\_\_  
Student number

\_\_\_\_\_  
Date